516-D GA1.13:HRD-88-79

United States General Accounting Office

GAO

Report to the Chairman, Committee on Finance, U.S. Senate

COMPLETED

March 1988

MEDICARE

Potential Effects of Shifting the Home Health Benefit From Part A to Part B

GAO/HRD-88-79

ORIGINAL

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-230520

March 25, 1988

The Honorable Lloyd M. Bentsen
Chairman, Committee on Finance
United States Senate

Dear Mr. Chairman:

Your March 4, 1988, letter asked for our analysis of the potential consequences of a provision in the House-passed Medicare Catastrophic Protection Act of 1987 (H.R. 2470) that would shift most payments for home health care from Medicare's Hospital Insurance Program (part A) to its Supplementary Medical Insurance Program (part B). You also enclosed a letter from the National Association for Home Care (NAHC) setting forth its concerns about and opposition to this proposed shift.

In summary, shifting home health care payments from part A to part B should not directly affect coverage of services under the home health benefit, the amount of Medicare expenditures for these services, or the way in which the benefit is administered. It would, however, change the financing source for the benefit from Social Security payroll taxes, which fund part A, to beneficiary premiums and general revenues, which fund part B. Many of NAHC's concerns relate to the potential political consequences of such a funding source change.

The Medicare Program

Medicare, authorized by title XVIII of the Social Security Act, is a health insurance program that helps almost all Americans age 65 or over and some disabled persons pay for needed health services. Medicare consists of two parts:

- Part A, Hospital Insurance for the Aged and Disabled, covers inpatient hospital services, skilled nursing facility services after a hospitalization, hospice services, and home health services. Part A is financed primarily by Social Security taxes on wages. To be eligible for part A, a person must (1) be 65 years of age or older and eligible for payments under Social Security's old age retirement and survivors program, (2) have received Social Security disability benefits for 24 months, or (3) suffer from end stage renal disease and be fully or currently insured under title II of the act. In fiscal year 1987, part A expenditures totaled about $50.8 billion.
- Part B, Supplementary Medical Insurance for the Aged and Disabled, is a voluntary program that covers physician services and a number of other health services, such as laboratory, outpatient hospital, and home

health services. Part B is financed by enrollee premiums (currently set by law at an amount necessary to cover 25 percent of total costs) and federal general revenues. Any citizen, or legal alien who has resided in the United States for at least 5 years, age 65 or older, is eligible for part B. In addition, disabled persons and end stage renal disease patients eligible for part A are also eligible for part B. In fiscal year 1987, part B expenditures totaled about $30.8 billion.

The Health Care Financing Administration (HCFA), within the Department of Health and Human Services (HHS), administers Medicare. HCFA is assisted by insurance companies that contract with it to process and pay claims. Part A contractors are called intermediaries, and part B contractors are called carriers.

Home Health Services Under Medicare

Home health services consist of skilled nursing services; physical, speech, and occupational therapy services; and medical social services provided in a patient's home. If the patient requires skilled nursing or therapy services, home health aide services, which are more of a personal care nature, are also covered.

The home health benefit is designed to provide the health services that beneficiaries who are confined to their homes need for an acute condition that would otherwise require institutional care. Most home health care services paid by Medicare are provided during the recovery period after a hospitalization.

Medicare's deductibles and coinsurance do not apply to home health services,[1] and no limit is placed on the number of visits. Home health services are covered under both part A and part B. However, payment for such services is always made under part A unless the beneficiary is only covered by part B.

Home health agencies are paid on the basis of their reasonable costs of providing covered services. All home health claims are processed and paid by the intermediaries regardless of whether they are covered under part A or part B. Medicare uses 10 regional intermediaries to pay claims from home health agencies not associated with a hospital. Hospital-based home health agencies can use the same intermediary that the hospital uses.

[1]The only exception is that beneficiaries are required to pay a 20-percent coinsurance for durable medical equipment, such as hospital beds and oxygen equipment, furnished by home health agencies.

The Proposed Shift From Part A to Part B

Section 105 of H.R. 2470, the Medicare Catastrophic Protection Act of 1987, as passed by the House on July 22, 1987, would revise the Medicare statute to provide that home health services would be paid under part B unless a beneficiary is only covered by part A. This is the opposite of current law. Virtually no changes in coverage of, payment method for, or administration of home health services would directly result from this proposed change. The exception to this relates to the availability of hearings before an administrative law judge concerning claims denials (see p. 5).

In its report on H.R. 2470 (House Report 100-105, part 1), the House Committee on Ways and Means states that the home health benefit should be transferred to part B to help maintain the solvency of the Hospital Insurance Trust Fund. The report also points out that there would be no change in the law regarding the part B premium calculation, so the 1989 premium would rise by the same percentage as Social Security retirement benefits; that is, shifting the home health benefit to part B would not affect the 1989 part B premium amount.

Potential Effects of Shifting the Benefit

Because section 105 of H.R. 2470 would not alter coverage under or administration of the home health benefit, total Medicare costs for home health care should not change as a result of a switch from part A to part B. However, the change would affect the funding source for home health care and, therefore, can be expected to affect the solvency of the Hospital Insurance Trust Fund and the deficit related to general revenues. The switch would affect the amount of beneficiary premiums for part B.

Solvency of the Part A Trust Fund

Regarding the solvency of the Hospital Insurance Trust Fund, in fiscal year 1987, about $2.4 billion was paid from that fund for home health services. Part A home health expenditures increased at an average rate of about 20 percent per year during fiscal years 1980-87. Making part B the normal payor for home health would transfer most of this expense from part A.[2]

The 1987 trustees' report for the part A trust fund estimated that, under intermediate economic assumptions,[3] the trust fund would be

[2]About 1 percent of the people enrolled in part A are not enrolled in part B. Part A would continue to fund home health care for these people.

[3]Projections are made based on four sets of economic assumptions—optimistic, pessimistic, and two sets of intermediate assumptions.

exhausted between 2002 and 2005. Removing most home health costs from part A should extend the depletion date, all other things being equal.

Need for General Revenues

Under current rules for the unified federal budget, both parts of Medicare are counted in determining whether there is a surplus/deficit in the budget. Therefore, switching the home health benefit from part A to part B would not affect the reported deficit. However, the switch would affect federal requirements for general revenues because part B is funded from enrollee premiums and general revenues while part A is funded from Social Security taxes. Thus, transferring costs from part A to part B would increase the need for general revenues. Part A trust fund money can be used to pay for services and related administrative costs or to buy federal securities when the fund has a surplus. Therefore, the savings to the part A trust fund from switching would be available to pay for other part A services or to lend to the Treasury for use, in turn, as general revenues.

Effect on Beneficiary Premiums

The original Medicare statute called for part B premiums to fund 50 percent of program costs and for general revenues sufficient to cover the other 50 percent to be appropriated to the part B trust fund. The Congress amended this provision through section 203 of the Social Security Amendments of 1972 to limit the percentage increase in the part B premium to the lower of (1) the percentage increase necessary to produce premiums equal to 50 percent of program costs or (2) the percentage increase in benefits under title II of the Social Security Act. Every year since this change the increase has been (or would have been without subsequent amendment) limited to the increase in title II benefits, primarily because part B costs have increased at a faster rate than the Consumer Price Index, which is the basis for the increase in title II benefits. By 1983, premiums were funding less than 25 percent of total costs.

Section 124 of the Tax Equity and Fiscal Responsibility Act of 1982 provided that the premium would be set at 25 percent of program costs for the annual premium years from July 1983 through June 1985. Section 606 of the Social Security Amendments of 1983 changed the part B premium year to coincide with the calendar year effective January 1, 1984, and extended the 25 percent of program cost provision through December 1985. Section 2302 of the Deficit Reduction Act of 1984 further extended the 25-percent provision through December 1987 and section 9313 of the Consolidated Omnibus Reconciliation Act of 1985 extended

the provision through December 1988. Finally, section 4080 of the Omnibus Budget Reconciliation Act of 1987 extended the 25-percent provision through December 1989.

As mentioned above, about $2.4 billion was expended from the part A trust fund for home health services in fiscal year 1987, when about 31.3 million beneficiaries were covered. This equates to about $80 per beneficiary per year, or about $6.70 per month. Because the 25 percent of total part B cost for premium calculation provision has been extended through 1989, switching home health to part B would result in an increase of $1.70 per month in the beneficiary premium (plus the percentage increase in home health costs since fiscal year 1987). At the time the House passed H.R. 2470, this effect was not envisioned because the 25-percent provision was due to expire at the end of 1988. The administration has requested as part of its 1989 legislative proposals that the 25-percent provision be made permanent.

Under current law, the increase in the 1989 part B premium that would result from switching the home health benefit to part B would be taken into account in determining subsequent premium amounts.

Concerns Expressed by NAHC

NAHC's March 1, 1988, letter to you expressed a number of concerns about switching the home health benefit from part A to part B and concluded by opposing a switch. Most of the concerns related to whether a future Congress faced with serious budgetary pressures would be more likely to reduce home health care benefits under part B rather than part A. We are not in a position to comment on the validity of these concerns.

NAHC also expressed concern that beneficiaries would have diminished appeal rights for home health services if the benefit were switched to part B because in general the amount in controversy necessary to obtain a hearing before an administrative law judge is $100 under part A but $500 under part B. We agree this would be the case unless H.R. 2470 were revised to apply the part A criteria to home health services under part B.

Objectives, Scope, and Methodology

As requested, our objective was to assess the potential consequences of shifting Medicare's home health benefit for most beneficiaries from part A to part B. We based our analysis primarily on our knowledge of the Medicare program in general and its home health benefit in particular.

We reviewed the Medicare statute and amendments to it related to the home health benefit and the computation of part B premiums. We also reviewed H.R. 2470 as passed by the House and the Committee reports related to it.

As requested by your office, we will not make further distribution of this report for 14 days unless you publicly disclose its contents before then. At that time, we will send copies to other interested committees and parties and to the Secretary of Health and Human Services.

Sincerely yours,

Michael Zimmerman
Senior Associate Director

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